REQUEST FOR USE OF MEDICAL RESTRAINTS

Completion of this form is voluntary. Although completion of this form is voluntary, all the information requested on this form needs to be submitted as part of the approval process. Department approval authority: Wis. Stats. § 50.02(2) and § 51.61(1)(i). Wis. Admin. Code § HFS 83.21(4)(n)4 and § HFS 94.10.

Name – Consumer	Birth Date
Current Address – Consumer	Type of Request ☐ New ☐ Review
City, State, Zip Code	

Name – Guardian	Telephone Number – Guardian
Address – Guardian	
City, State, Zip Code	

Current Residence – Consumer

- ☐ Personal Residence (same address as above)
- ☐ Licensed or Certified Facility (provide name and address below)
- ☐ Other (describe and provide address below)

Facility Name	Facility Type
Facility Address	Telephone Number
City, State, Zip Code	FAX number

Is the consumer's proposed placement other than the current residence?
☐ Yes (provide name below) ☐ No

Name – Facility	Facility Type
Address – Facility	Telephone Number
City, State, Zip Code	FAX Number

Name – Agency Submitting This Request	Date Submitted
Contact Person	Telephone Number
Agency Address	FAX Number
City, State Zip Code	
Email Address	

DEFINITIONS: A **Medical Restraint** is an apparatus or procedure that restricts the free, voluntary movement of a person **and** cannot be easily removed by the individual **and** a "Yes" to one of the following. Check Yes or No if the following apply.

Yes	No		
☐	☐	**MEDICAL PROCEDURE RESTRAINT**	Medical procedure or apparatus restraint used when necessary to accomplish diagnostic or therapeutic procedures ordered by a physician, physician's assistant or dentist.
☐	☐	**RESTRAINTS ALLOWING HEALING**	Restraints for health-related conditions in order to allow healing of an injury. Examples of circumstances requiring healing may include lacerations, fractures, post-surgical wounds, skin ulcers and infections.
☐	☐	**LONG TERM RESTRAINTS**	Restraints used for protection from injury in the presence of a chronic health condition. An example is using a safety belt to protect an individual who has severe osteoporosis and ataxia.

If the answer to the Medical Restraint and any of the above definitions is YES, continue.

PERSONAL SUMMARY

Type of Employment

Support Systems (name, address, telephone and relationship)

Interests

Dislikes

HEALTH CONSIDERATIONS

Diagnoses

Health Concerns

MEDICATIONS

Medication	Dose	Purpose	Prescribing Physician

HEALTH PROVIDERS

Specialty	Name	Address	Telephone
Primary Physician			
Psychiatrist			
Psychologist / Therapist			
Neurologist			
Other:			
Other:			
Other:			

MEDICAL CONDITION REQUIRING RESTRAINT

Describe the person's medical conditions and the situations in which they occur.

Describe the frequency and duration of use.

Provide written authorization by a physician which identifies the type of medical restraint ordered, the indication for its use and the time period for its application.

PREVIOUS ALTERNATIVE STRATEGIES OR INTERVENTIONS ATTEMPTED

List and explain previous alternative strategies or interventions, when they were tried, how long they were tried and the outcomes

1. Strategy

   Outcome

2. Strategy

   Outcome

3. Strategy

Outcome

4. Strategy

Outcome

CURRENT AND PROPOSED STRATEGIES

Describe or attach a copy of the current and proposed strategies and safeguards for the medical condition. Include staffing patterns, level of supervision, restrictions or limitations. Attach the current care plan, OT and PT evaluations, physician's orders, and informed consent by the consumer or guardian.

RISK AND BENEFITS

Describe a risk and benefit analysis for the use of the medical restraint.

MEDICAL RESTRAINT

Identify the proposed medical restraint and why these strategies are needed.

ATTACH RELEVANT PHOTOS, MANUFACTURER SPECIFICATIONS OR LITERATURE.

Procedure / Device	Purpose	Plan (Specify where procedure or device is used, when, length of time, etc.)	Desired Outcome

REDUCTION AND ELIMINATION PLAN FOR RESTRAINTS

Describe or attach a copy of the plan for reducing and eventually eliminating the need for the medical restraint.

TRAINING

Describe or attach a copy of the plan to provide initial and on-going training for staff. Identify who will conduct the training, his/her credentials, the duration of training and how training will be documented.

REVIEW

Describe or attach a description of how the plan will be monitored, documented and reviewed.

SUPPORT PLAN CONTRIBUTORS / DEVELOPERS

Name	Relationship to Consumer

PLAN REVIEW

Plan Reviewed By	Name	Signature	Date Reviewed
Consumer, if not under guardianship*			
Guardian, if applicable*			
Placing Agency*			
Provider Agency*			
Primary Physician			
Other:			
Other:			
Other:			

*required signatures.